

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

November 10, 2025

[REDACTED]
BRISTOL HOUSE MEMORY CARE LLC
[REDACTED]

RE: BRISTOL HOUSE MEMORY CARE
2527 BRISTOL ROAD
WARRINGTON, PA, 18976
LICENSE/COC#: 14458

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/16/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: BRISTOL HOUSE MEMORY CARE License #: 14458 License Expiration: 02/21/2026
 Address: 2527 BRISTOL ROAD, WARRINGTON, PA 18976
 County: BUCKS Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: BRISTOL HOUSE MEMORY CARE LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 03/19/2019 Issued By: Warrington Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 78 Waking Staff: 59

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 09/16/2025

Inspection Dates and Department Representative

09/16/2025 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 48 Residents Served: 39
 Secured Dementia Care Unit
 In Home: Yes Area: entire home Capacity: 48 Residents Served: 39
 Hospice
 Current Residents: 11
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 38
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 39 Have Physical Disability: 0

Inspections / Reviews

09/16/2025 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/17/2025

10/28/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 10/31/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/30/2025

Inspections / Reviews (*continued*)

10/29/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/31/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 10/31/2025

11/10/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/31/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [REDACTED], the home's license inspection summary, dated [REDACTED], was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept [REDACTED] - 10/24/2025)

1. Violation was corrected on site of inspection on 9/16/25. Executive Director printed new copy of license inspection summary date 12/30/24 and placed into a secure binder at Front Desk and posted a sign in conspicuous place that states Licensing Inspection Summaries are available upon request. Pictures of items in place will be provided with plan of correction.

2.Executive Director educated Front Desk Staff on 10/13/2025 that the hard copy of licensing inspections summaries must always remain in Licensing Inspection Summary Binder at Front Desk.

3. To prevent further violations the Executive Director will Audit Licensing Inspection Summary Binder Monthly effective October 2025 to ensure current inspection summary is present.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [REDACTED] - 11/10/2025)

26b - Quality Management Plan Content

2. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

- 1. The reportable incident and condition reporting procedures.
- 2. Complaint procedures.
- 3. Staff person training.
- 4. Licensing violations and plans of correction, if applicable.
- 5. Resident or family councils, or both, if applicable.

Description of Violation

The home does not have resident council meeting minutes for [REDACTED] to [REDACTED].
The home does not have quality management meeting minutes since [REDACTED].

Plan of Correction

Accept [REDACTED] - 10/24/2025)

1. Executive Director educated the Director of Activities on regulation 26b on 10/15/2025 on utilizing Resident Council Form each month and providing a copy for the State Binder.

2. Will review Resident Council Quarterly at QA Meeting. Next QA meeting to be held on 10/20/2025.

3. QA meeting to be held Quarterly starting 10/20/2025

26b Quality Management Plan Content (continued)

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [REDACTED] 11/10/2025)

51 - Criminal Background Check

3. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home has [REDACTED] residents receiving hospice services. The home does not have criminal background checks for serenity hospice staff.

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/24/2025)

1. Violation was corrected on site of inspection on 09/16/2025 and criminal background for Serenity Staff was obtained by Executive Director and placed in 3rd party vendor binder and placed in business office. Review of all Third Party Vendors that services residents in community was reviewed and all background checks obtained and in place in 3rd party vendor binder.
2. On 10/13/2025 Executive Director educated, Director of Nursing, Business Office Manager, Business Office Assistant, and Activity Director on Regulation 51 that all Vendors providing services directly to a resident must supply community with Background checks for all of their staff members providing service to a resident.
3. To prevent further violations the review of the 3rd party vendor binder will be reviewed at the at the QA meeting to be held on Monday, October 20th 2025 and Quarterly thereafter.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [REDACTED] - 11/10/2025)

62 - Contact List

4. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, the administrator, did not have a complete staff list to include agency staff.

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/24/2025)

1. Violation was corrected on 9/17/2025 and Agency Staff List was obtained from Business Office Manager and placed in State Binder.
2. On 10/13/25 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 62 that a current staff list must be kept on file and up to date to include both regular and agency staff.
3. To prevent further violations the Business Office Manager will provide Business Office Assistant with a list of all

62 Contact List (continued)

new hires on day of hire to add to current employee and agency staff list. List will be updated weekly by Business Office Assistant, printed and provided to Executive Director to be placed in state binder to be available upon future inspections

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [redacted] - 11/10/2025)

65e - 12 Hours Annual Training

5. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

- 1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
- 2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received only 2 hours of annual training in training year 2024.

Repeat Violation: [redacted]

Plan of Correction

Accept [redacted] - 10/24/2025)

- 1. On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 65 e to ensure compliance. Business Office Assistant, will complete audit on all staff training hours of in person/online Relias training. Audit of employee training to be completed by 10/24/2025 to ensure compliance will be met by all staff by 12/31/2025.
- 2. On 10/15/2025 at All Staff meeting, Executive Director educated all staff on the yearly requirement for training and their responsibility to complete online and in person training per the Staff Annual Training Plan.
- 3. To prevent future violations effective 10/2025 Monthly Audit to be completed by Business Office Assistant to ensure all staff completed scheduled monthly in person and online Relias training to ensure all staff are current with training completed according to annual training plan and per regulation 65e 12 hours of Annual Training. Department Supervisor to be notified of any staff member out of compliance to ensure completion of Training.

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] - 11/10/2025)

65f - Training Topics

6. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.
- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- 3. Care for residents with dementia and cognitive impairments.

65f - Training Topics (*continued*)

4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B did not receive training the following during training year 2024:

- *Medication self-administration training.*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.*
- *Personal care service needs of the resident.*
- *Safe management techniques.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Repeat Violation [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/28/2025)

1. *Beginning on 10/13/2024 Business Office Assistant began Audit of all staff training records to determine compliance with regulatory requirements. Audit to be completed by 10/24/2025.*
2. *On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 65 f. and process moving forward to ensure regulatory compliance.*
3. *On 10/15/2025 All staff educated on the yearly requirement for training and their responsibility to complete online and in-person training per the Staff Annual Training Plan to ensure training topics completed per regulation 65.f are met.*
4. *To prevent future violations Monthly Audit to be completed by Business Office Assistant effective 10/2025 and Monthly thereafter to ensure all staff completed scheduled monthly in-person and online Relias training and that all staff are current with training completed according to annual training plan that is designed to meet regulation 65 f 's training topics. Audit of employee training to be completed by 10/24/2025 to ensure compliance on training topics per regulation 65.f will be met by all staff by 12/31/2025*

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/10/2025)

65g - Annual Training Content

7. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

65g Annual Training Content (*continued*)

6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training on the following during training year 2024:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*
- *Resident rights.*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102).*
- *Falls and accident prevention.*
- *New population groups that are being served at the home that were not previously served, if applicable.*

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] 10/28/2025)

1. *Beginning on 10/13/2024 Business Office Assistant began Audit of all staff training records to determine compliance with regulatory requirements. Audit to be completed by 10/24/2025.*
2. *On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 65 g. and process to ensure compliance going forward.*
3. *On 10/15/2025 All staff educated on the yearly requirement for training and their responsibility to complete online and in person training per the Staff Annual Training Plan.*
4. *To prevent future violations Monthly Audit to be completed by Business Office Assistant effective 10/2025 and monthly ongoing to ensure all staff completed scheduled monthly in person and online. Audit of employee training to be completed by 10/24/2025 to ensure compliance with regulation 65g. A list of staff missing training will be provided to department supervisors to ensure completion.*

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [REDACTED] - 11/10/2025)

82c - Locking Poisonous Materials

8. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Clorox beach toilet bowl cleaner, with a manufacture's label indicating " Immediately call a poison center or doctor. If swallowed rinse mouth. Do not induce vomiting. If on skin or hair take off immediately all contaminated clothing. Rinse skin with water. Wash contaminated clothing before reuse. If inhaled: Remove person to fresh air and keep comfortable for breathing. If in eyes: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing", was unlocked, unattended, and accessible to resident [REDACTED] in their bathroom. Not all the residents of the home, including resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

Lysol Disinfecting wipes, with a manufacture's label indicating hold eye open and rinse slowly and gently with water

82c - Locking Poisonous Materials (continued)

for 15-20 minutes. Remove contact lenses, If present after the first 5 minutes, then continue rinsing the eye. Call a poison control center or doctor for treatment advice", was unlocked, unattended, and accessible to resident [REDACTED] in their bathroom. Not all the residents of the home, including resident [REDACTED], have been assessed capable of recognizing and using poisons safely.

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/28/2025)

1. Corrected on site at time of inspection on 9/16/2025 Housekeeper immediately removed Poisonous materials and Housekeeper Immediately educated by Resident Care Coordinator on the importance of removing all poisons upon exiting resident rooms despite circumstances.
2. On 10/15/2025 All staff educated on Regulation 82.c and locking up all poisonous materials.
3. To prevent future violations Maintenance Director and/or designated person will conduct daily room sweeps to ensure compliance with regulation 82.c effective 9/17 and ongoing. Person conducting daily room sweeps will report any non-compliance to Director of Nursing and/or Executive Director to allow for re-education.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [REDACTED] 11/10/2025)

91 - Telephone Numbers

9. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room [REDACTED]

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 10/28/2025)

1. Corrected on Site at time of inspection on 9/16/2025 Executive Director posted Emergency Numbers in resident room 110 on back of front door.
2. On 10/13/2025 Executive Director completed Audit on all Resident rooms completed by and Emergency Phone Numbers posted on all resident doors.
3. On 10/15/2025 Executive Director educated staff at monthly staff meeting on Regulation 91 and that we as a team need to ensure that Emergency numbers remain posted on back of residents front door. If they find a room not to have Emergency Numbers posted in resident room they can obtain a new one from the front desk.
4. To prevent future violations Maintenance person and/or designee will include audit of Emergency numbers posted along with daily room sweeps. Additional Signs will be available at front desk.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [REDACTED] - 11/10/2025)

95 - Furniture and Equipment

10. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident [redacted] did not have a toilet paper holder in their bathroom.

Plan of Correction

Accept [redacted] - 10/28/2025)

- 1. Violation was corrected on site of inspection on 9/16/25, maintenance person replaced toilet paper holder.
- 2. On 10/15/2025 Executive Director educated staff at monthly staff meeting on Regulation 95 and that we as a team need to ensure that all resident rooms must have the appropriate furniture/equipment in place and that it must be in good working order.
- 3. To prevent future violations Maintenance person and/or designee will include audit of toilet paper holders with daily room sweeps effective 09/17/25 and ongoing.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [redacted] - 11/10/2025)

102h - Toilet Paper

11. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On [redacted] at 10:07 am, there was no toilet paper for the toilet in the bathroom in resident room [redacted].

Plan of Correction

Accept [redacted] - 10/28/2025)

- 1. Violation corrected on site at time of inspection on 9/16/25 Housekeeper placed toilet paper in resident bathroom
- 2. On 10/15/2025 Executive Director educated staff at monthly staff meeting on Regulation 102h and that we as a team need to ensure that all resident rooms Must have ample supply of toilet paper.
- 3. To prevent future violations Maintenance person and/or designee will include audit of toilet paper with daily room sweeps effective 09/17/25 and ongoing.

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [redacted] - 11/10/2025)

107d - Procedure Emergency Management Agency Submission

12. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home could not provide proof that the home's written emergency procedures had been submitted to the local emergency management.

107d - Procedure Emergency Management Agency Submission (continued)

Repeat Violation: [REDACTED]

Plan of Correction

Accept [REDACTED] 10/28/2025)

- 1. Executive Director is reviewing and updating emergency procedures for accuracy and will send written emergency procedures to local emergency management on October 20th, 2025. Upon final review at QA Meeting on 10/20/2025. Document will be added to state binder and digital copy to be kept on file.
- 2. To prevent future violations Executive Director will send written notification per regulation 107.d annually or upon any changes. Copy to be placed in Emergency Procedure Binder and Digital copy to also be retained. State Binder to be reviewed Quarterly at QA Meeting. Next QA Meeting 10/20/2025.

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented ([REDACTED] - 11/10/2025)

124 - Notice to Fire Department

13. Requirements

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept [REDACTED] - 10/28/2025)

- 1. Executive Director send Fire Department written notification per regulation 124 on 10/15/2025.
- 2. To prevent future violations Executive Director will send written notification per regulation 124 every time there is a census change within the community and add the letter to the state binder. Digital copy to also be retained and State Binder to be reviewed Quarterly at QA Meeting. Next Meeting 10/20/2025

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented [REDACTED] 11/10/2025)

131e - Accessible Extinguishers

14. Requirements

2600.

131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

The fire extinguishers throughout the building are not kept locked and allowing residents to have access to the fire extinguishers. According to staff person A, a resident has been removing the inspection tags.

Plan of Correction

Accept ([REDACTED] 10/28/2025)

- 1. There has never been an issue with resident accessing and removing fire extinguishers only have they removed

131e - Accessible Extinguishers (continued)

- the wired inspection tags. On 9/19/25 Oliver/fire service company placed inspection tags with an adhesive tag placed directly on fire extinguisher and unable to remove them.*
- 2. Internal cabinet mounts to secure fire extinguishers within cabinets were ordered on 10/15/25 and will be installed by 10/30/2025.*
- 3. Starting 10/2025 Maintenance personnel will conduct monthly audit of Fire Extinguishers to ensure they are secure and tagged. Document of monthly Audit to be retained in Fire Safety Binder.*

Licensee's Proposed Overall Completion Date: 10/30/2025

Implemented [redacted] - 11/10/2025)

131f - Fire Extinguisher Inspection

15. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher near resident rooms [redacted] and [redacted] did not have an inspection tag.

Plan of Correction

Accept [redacted] - 10/28/2025)

- 1. Violation occurred because resident in room [redacted] was removing the inspection tags from the fire extinguishers. Violation was corrected on 9/19/25 by Oliver the fire extinguisher inspection provider. The twist on tags were replaced with an adhesive tag that could not be removed. Resident that was removing the inspection tags has since moved out of the community.*
- 2. On 10/13/25 Executive Director Educated Maintenance Person, Director of Nursing, Business Office Manager, Business office Assistant, Activities Director on regulation 131 f and to notify Executive Director if inspection stickers are removed.*
- 3. To prevent further violations the Maintenance person and/or designee will provide monthly audit of fire extinguishers effective 10/2025 and monthly ongoing to ensure inspection tag is intact per regulation 131f. Monthly Inspection sheet to be retained in Fire Safety Binder.*

Licensee's Proposed Overall Completion Date: 10/18/2025

Implemented [redacted] - 11/10/2025)

132d - Evacuation

16. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on [redacted] at 11:39 am, evacuation time documented was 24 minutes and 2 seconds. The

132d - Evacuation (continued)

home had a maximum safe evacuation time of 15 minutes specified in writing by a fire safety expert dated [REDACTED]

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- [REDACTED] at 1:28 pm evacuation time documented was 7 minutes and 52 seconds.
- [REDACTED] at 7:02 pm evacuation time documented was 14 minutes and 25 seconds.
- [REDACTED] at 11:05 pm evacuation time documented was 6 minutes and 39 seconds.

Plan of Correction

Accept [REDACTED] - 10/28/2025)

On 9/26/2025 Fire & Life Safety Solutions Came out to the home and completed annual inspections and provided us with our Written Evacuation Letter. Prior letter on file was dated 6/26/24. We did not realize this had to be within a year from prior date.

To prevent further violations Executive Director will schedule with provider to come out annually on a renewal schedule to ensure updated written letter for the year. Evacuation letter dated 9/26/25 was placed in Fire Safety Binder and one in State binder. Both binders to be reviewed at quarterly QA Meeting. Next QA meeting to be held on 10/20/2025

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented [REDACTED] - 11/10/2025)

141a 1-10 Medical Evaluation Information

17. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [REDACTED]'s medical evaluation dated [REDACTED] did not include special health or dietary needs of the resident this section was not filled out.

Resident [REDACTED] medical evaluation dated [REDACTED] did not include the resident's need for a wheelchair.

Plan of Correction

Accept [REDACTED] - 10/28/2025)

1. DMEs were immediately corrected by the DON with consent of physician

141a 1-10 Medical Evaluation Information (continued)

- 2. DON will complete a 100% audit of all charts for regulatory required documents by 10/15/2025
- 3. ED provided education to DON on 10/6/2025 on regulation 141(a)2
- 4. DON will complete a 10% audit of charts monthly for regulatory required documents beginning 11/1/2025 for 6 months. Documentation will be kept
- 5. Audits will be reviewed with ED at quarterly QA meetings. Next QA Meeting to be held on 10/20/2025

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented [redacted] - 11/10/2025)

162c - Menus Posted

18. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of [redacted] and the following week was not posted in Gold Finch neighborhood and Blue Jay neighborhood.

Plan of Correction

Accept [redacted] - 10/28/2025)

- 1. Executive Director Corrected onsite during inspection and posted menus in both Goldfinch and BlueJay Dining rooms
- 2. On 10/15/2025 Executive Director Educated Chef on Regulation 162c and that a minimum of 2-week dining menu is to be posted in both Goldfinch and Bluejay Dining Room
- 3. To prevent further violations Executive Director and/or designee will check dining rooms for posted menus monthly for 6 months starting 10/2025.

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented [redacted] - 11/10/2025)

185a - Implement Storage Procedures

19. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [redacted] has a physician order for blood glucose checks at 8:00 am, 12:00 pm, and 5:00 pm. On [redacted] at 4:51 pm, the [redacted] level was documented as [redacted] on the resident's September 2025 medication administration record. However, the reading on the glucometer was [redacted]

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept () - 10/28/2025)

- 1. DON immediately checked glucometer against MAR for accurate documentation
- 2. DON will provide education to all medication technicians on regulation 185a by 10/16/2025
- 3. DON/designee will audit glucometers for accuracy weekly X 4 weeks, and monthly thereafter for 6 months. Documentation will be kept
- 4. Audits will be reviewed with ED at quarterly QA meetings. Next QA meeting to be held on 10/20/2025.

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented () - 11/10/2025)

227g -Support Plan Signatures

20. Requirements

- 2600.
- 227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident () participated in the development of () support plan on (). However, the resident did not sign the support plan.

Resident () participated in the development of () support plan on (). However, the resident did not sign the support plan.

Plan of Correction

Accept () - 10/29/2025)

- 1. RASP were immediately corrected by the DON
- 2. DON will complete a 100% audit of all charts for regulatory required documents by 10/15/2025
- 3. ED provided education to DON on 10/6/2025 on regulation 227g
- 4. DON will complete a 10% audit of charts monthly for regulatory required documents beginning 11/1/2025 for 6 months. Documentation will be kept
- 5. DON will make 2 Attempts to obtain Resident Signature if deemed unable to sign DON will obtain signature of residents POS
- 6. Audits will be reviewed with ED at quarterly QA meetings. Next QA Meeting to be held on 10/20/2025

Licensee's Proposed Overall Completion Date: 10/30/2025

Implemented () - 11/10/2025)

233a - Lock Approval

21. Requirements

- 2600.
- 233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

233a Lock Approval (continued)

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the key locking devices and electronic card operated systems, used on the exit doors from the SDCU.

Plan of Correction

Accept [redacted] 10/28/2025)

1. Owner obtained letter of written approval from appropriate local building authority on 10/16/025
2. Digital copy to be kept on file and copy placed in State Binder for future inspections
3. Review of State Binder to be audited for compliance of necessary documents quarterly at QA Meeting. Next meeting to be on 10/20/2025

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented ([redacted] 11/10/2025)

233b - Lock Manufacturer Statement

22. Requirements

2600.

- 233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
 2. Power failure to the home.
 3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the magnetic locking system verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction

Accept [redacted] 10/28/2025)

1. On 9/17/2025 Executive Director obtained copy of Manufacturer Handbook on operation of magnetic locking system.
2. Executive Director placed a copy of handbook in State Binder/Electronic Copy of handbook to be kept on file
3. To prevent further violations Electronic Copy of Manufacturer handbook to be kept on file in state binder and digitally. State Binder to be reviewed quarterly at QA Meeting. QA meeting to be held 10/20/2025

Licensee's Proposed Overall Completion Date: 10/20/2025

Implemented ([redacted] - 11/10/2025)

236 - Staff Training

23. Requirements

2600.

236 - Staff Training (continued)

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in dementia care during the 2024 training year.

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had only 0 hours of training in dementia care during the 2024 training year.

Repeat Violation: 10/17/2024

Plan of Correction

Accepted [redacted] - 10/28/2025)

1. Upon Initial audit of 2024 Training Binder it was found that staff person B had actually completed 2 of the 6 hours of required dementia training.
2. On 10/13/2025 Executive Director educated the Business Office Manager and Business Office Assistant on Regulation 236 Staff training and process to ensure compliance going forward.
3. On 10/15/2025 All staff educated on the yearly requirement for training and their responsibility to complete online and in person training per the Staff Annual Training Plan.
4. To prevent future violations Monthly Audit to be completed by Business Office Assistant effective 10/2025 and monthly ongoing to ensure all staff completed scheduled monthly in-person and online. Audit of employee training to be completed by 10/24/2025 to ensure compliance with regulation 236. A list of staff missing training will be provided to department supervisors to ensure completion and full compliance by 12/31/2025

Licensee's Proposed Overall Completion Date: 10/24/2025

Implemented [redacted] - 11/10/2025)